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ABSTRACT

Children and adolescents have different understandings of death. For the baby, death is equated with separation. For toddlers, grief occurs when they realize the person is not returning. The preschool child who tends to live in the present with no clear concept of past or future will not understand the finality. Around ages 4 and 5, death is often personified as a "boogie man." Eventually by the age of 6 or 7, children have developed a clear understanding of death very similar to that of adults. Children and adolescents' experience of a sibling's death usually includes sensations of somatic distress, intense preoccupation with the image of the deceased person, strong feelings of guilt, loss of warmth towards others, and disorientation. Later adjustment problems of children and adolescents whose sibling had died include guilt that they should have died too and distorted concepts of illness and death. Parents have reported that these events were helpful in adjustment to the death: having knowledge of the diagnosis and the likely fatal outcome; participating in the patient's care; having the opportunity to say good-bye in the terminal phase; having the sibling die at home; seeing the dead body; attending the funeral or cremation by choice; being given some of the patient's possessions; and previously experiencing the death of a close relative or pet. (ABL)

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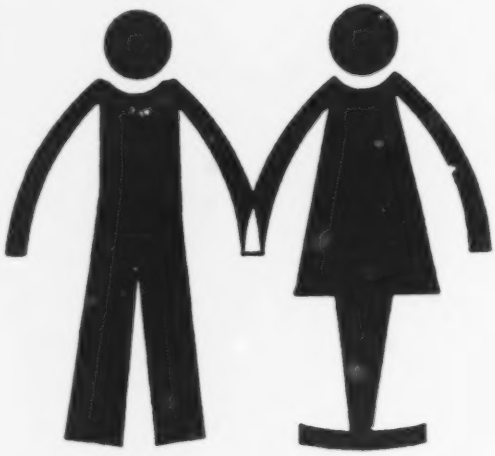

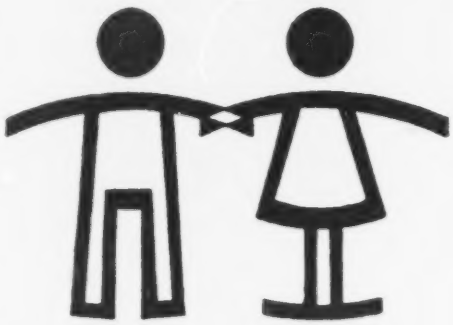

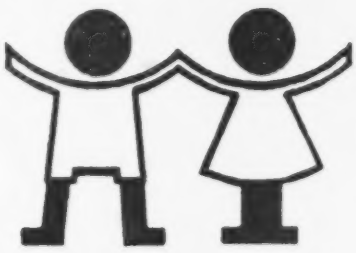

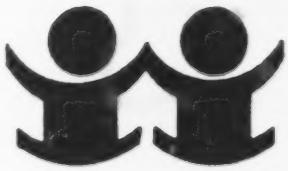

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A DYING CHILD IN THE FAMILY: THE CHILD"S AND SIBLING"S PERSPECTIVE.

John Said

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A DYING CHILD IN THE FAMILY:

THE CHILD'S AND SIBLING'S PERSPECTIVE.

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OVERVIEW: The structure of this paper is as follows:

1. The child's and the adolescent's understanding of death.
2. The child's and the adolescent's experience of his own death.
3. The child's and the adolescent's experience of a sibling's death.
4. Later adjustment problems in siblings.

THE CHILD'S AND THE ADOLESCENT'S UNDERSTANDING OF DEATH

This topic is one that upsets and saddens most of us. The reason I agreed to write this paper is that our culture's understandable avoidance of discussion on children's death makes it difficult for us to help children and adolescents who are dying. They often die surrounded by caring people, but lonely with their knowledge that they are dying because those same caring people cannot allow them to ask their most pressing questions.

Children 0 to 3

The child's understanding of death changes as the child achieves greater social and cognitive maturity. For a baby, death and separation are equated. If another person, such as a parent is away for a significant length of time, then the baby behaves eventually as if that person has ceased to exist. As infants learn to experience separation and the return of their care givers they develop an expectation that people will return. Therefore, if a toddler, for instance experiences the death of a sibling, then the toddler will show some signs of grief for that sibling when it is eventually realised that the sibling is not returning.

Children 3 to 6:

The pre-school child who tends to live in the present with no clear concept of past or future, will not understand the finality of death. The pre-school child is mostly concerned about death in terms of separation, fear of being abandoned and fear of loneliness. In attempting to understand what grief and bereavement mean it is necessary to understand what attachment means. Bereavement is basically the dissolving of attachment bonds that have been formed. George Bernard Shaw once said that love is a gross exaggeration of the difference between one person and everybody else. Attachment bonds do make certain people very special to us and when we lose these special people they cannot simply be replaced by other people. Instead we must go through a very painful process of dissolving the affectional bonds that we have formed with that particular person. The pre-schooler's notion of death is associated with separation and is usually seen as a reversible process. When the pre-schooler eventually realizes that the lost person will not return, then the child is likely to experience an inconsolable anguish which is very painful and threatening to adults who care for that child. This anguish can threaten to overwhelm the adult who experiences powerlessness in not been able to take away the anguish. This powerlessness can re-awaken the pain of the adult's earlier or current experiences of separation and loss or fear of loss. (Raphael, 1984). Yet it is only with the adult comforting the child that the child will learn to relinquish the bond with the lost person. Because pre-schoolers are not fully able to express themselves

verbally, play can be very important in helping the pre-school child express their feelings about their own impending death or the death of a sibling. Play can also help deal with the frightening aspects of death.

Around age four and five, death is often personified such as a "boogie man". This image of death is even used in adult culture such as when the Grim Reaper was presented to television viewers as a way of frightening them about the dangers of AIDS. At this stage children's fear of darkness can be associated with some sense that death is personified and lurks in the darkness threatening them. Children of this age also see violence and death on television and it is often presented in cartoon form as reversible. How many times does the poor fox recover after having been completely obliterated by the Road Runner? At this age there is a blurring of fantasy and reality. The reality experience of death may have been such experiences as the death of a pet or a plant, but many children at age five have no direct experience of the death of a person.

Children at this age can be very frightened of the sadness they see in bereaved adults. Those children who have some association with the death of a person usually learn very quickly from adult bereavement that death is irreversible. However, at this stage there is some comfort in their pre-operational thought, the egocentrism, magical thinking and the ability to deny, through fantasy, the hard facts of death.

Children 6 to 9 and older

Eventually by about age six or seven children have developed a clear undersanding of death that is very similar to the adults concept of death. This understanding will include the three key concepts of universality, non-functionality and irreversibility. (Speece and Brent 1984). That is, the child will understand that all living things and people will die, that death is an end of all functions and that death is not reversible. However, even these concepts are variously understood according to the beliefs of the family, especially their religious and cultural beliefs.

At the age of about six to nine, when concrete operational thought is developed, the child is able to take the role of another person cognitively and begins to understand the permanence of death. Speece and Brent (1984) found that the majority of healthy children in modern urban industrial societies achieve the basic understanding of death between the ages of five and seven. Children at this age may be very frightened by news footage which shows death in reality. Children of this age facing their own death or the death of a sibling may be terribly frightened about the bodily harm involved in death. One thing which can be done to deal with their fear of pain is to reassure the child that medicines can prevent the pain, and that there is nothing to be frightened of in death itself, because death has no pain, except for those who remain alive.

The adolescent usually has a concept of death like the adult's. Adolescents understand death's permanence and this is particularly hard for them to accept emotionally. Adolescents and adults will sometimes regress to younger modes of thinking when their mature understanding of death is too painful to tolerate.

THE CHILD'S AND ADOLESCENT'S EXPERIENCE OF THEIR OWN DEATH

Responding to the child's and adolescent's questions about death

It is most important that children be allowed to talk about death. The child whose own life is threatened will very readily become aware of this without somebody telling him or her. The sudden exposure to medical procedures, hospitalization, anxious glances between parents and between doctors and a generally stressed set of adult care givers makes even a very young child aware that they are in a very serious situation. Even young children in this situation will think about the threat of death. But children will interpret adult silence as a taboo on a subject and feel that they cannot ask. Some children have died very lonely with the knowledge that they are dying, but unable to share it with anybody because they have not been given the opportunity. Vernick (1980), cites a study by two French paediatricians, Rainbault and Royer (1967). In describing their interviews with and observations on ten children aged five through nineteen who were hospitalized with chronic diseases of serious prognosis, they concluded that chronically ill and

seriously ill children readily and realistically can, and wish to, speak about their fears, concerns and ideas about death and dying. Specifically they state "when the sick child has the possibility to freely express himself with an adult, he will approach the subject of death without restraint". It should be pointed out that in the interviews held by Rainbault and Royer, even with their youngest patients, straightforward, simple communication techniques were used. They found no need to become involved in complicated symbolic or interpretive techniques.

So, what should one say to the child about death? It is important to reply simply to the child's questions and not to elaborate more than the child really wishes. It is like answering the young child's questions about sex. Sometimes asking the child what the question means can help the adult clarify just how much the child wants to know. Children will frequently come out point blank and ask their parents "am I going to die?" An honest answer to the child is essential. It could be as follows, "All of us will die sometime, we don't really know when anyone is going to die. You seem afraid that you may die soon. Have you been worrying about dying? Let's talk about it if you want". Sometimes children are just seeking reassurance that they are not going to die there and then. Enquiring about the child's concerns may allow a broader discussion and may clarify what some of the child's fears are, such as fear of pain or fear of being left alone. Parents usually find that they can best approach questions about death by clarifying what the child is specifically asking, clarifying what the child already knows or believes or thinks and then giving some honest information that will be comprehensible to the child.

Most children will not want adults to guess when they are going to die. They will appreciate an open ended response like, "no-one knows how much time is left in a person's life". However, a child is usually well aware if their illness has entered a terminal phase and medical intervention to cure the disease is withdrawn. Children keep such a close watch on what their treatment involves. When a child has entered a terminal phase the child will often ask "am I going to die?" and the honest answer to this usually is that there is nothing more that medicine can do to make the child well again. Whether one should still give the child hope of recovery is a controversial issue. How one responds depends largely on whether the child appears to want to cling to some hope of survival or whether the child wishes to squarely face the facts of his impending death.

How Children and Adolescents Experience their Impending Death

Adolescence is so focused towards the future. There is a sense that the person is just beginning to have a separate identity and a separate life and this life is being cut short. This can lead to intense feelings of anger, sadness and depression in the adolescent. Much of the adolescent's time and energy is spent learning self-sufficiency. So facing death is in complete conflict with this striving for independence. One fourteen year old boy who talked a lot to me about his death was very angry with me that I had lived for so many years already and he would have such a short life. He was also very cruel to his younger brother. He was angry with God for giving him cancer, but before he died he talked about the fact that he had spoken with God and no longer felt so bad about dying. This boy's religious beliefs helped him accept his impending death. Prior to this stage of acceptance he had been extremely angry and hurtful with his family and his brother.

Some adolescents deal with their loss of a future by trying to cram a number of experiences into their short years. It can be a most important milestone to have achieved one's driver's licence or to have a car. When a 17 year old boy went home for terminal care last year he wanted to die in the back of his panel van. Adolescents want to be remembered and so they often leave diaries to particular people, or leave special objects, that they value very much, to particular people; they write letters and they may even sponsor an animal at the zoo so that their name will appear on a plaque as a sponsor, and they will be remembered.

Children in an oncology unit are usually more acutely aware of death than other children their age. Sometimes they have been in the ward when a child has died or they notice that a familiar child is suddenly absent from an outpatient clinic and they ask the obvious questions. Sometimes a child or teenager chooses to attend the funeral of a fellow patient. Dr. Susan Perry, in an unpublished manuscript entitled *The Dilemma of Faust: How a fourteen year old girl made her decision when to die from leukemia*, includes a poem written by her patient Nicky, after Nicky had attended a fellow-patient's funeral. This is that poem:

I walked through the door, expecting not what I saw,
A sacred church all gleaming with gore,
Oh please release me from what I saw,
Such mournful people, in black they wore,
Why them? Why me? Why more?
Why wait, when hating what I saw,
Why not retreat before seeing so much more?
Such painful sights before me,
me making more,
Please let me free. I see more,
The picture all scented with death.
The hole church seemed to revel,
Why was I qualming when they were so quiescent?
God, only, should know.

Children and adolescents may ask what actually happens after he or she dies. The responses to such questions depend largely on the family's belief system. When the question is turned around and the child or adolescent is asked the same question, some will come out point blank and say "You get buried and you rot" or "You get burnt". This is the hard fact of the reality of death, but the child or adolescent may also wish to believe in some life after death and to hold some hope in an eventual re-union with those who love him or her. He or she can be reassured that life ends at death and so nothing actually happens to the person since that person is no longer there. The dying child or adolescent will gain reassurance and security from the love of the family and needs the closeness of loved ones and the confidence that they will be present right up to the point of death. Therefore, parents and older siblings will often need special assistance to prepare them for this emotionally demanding task.

THE CHILD'S AND ADOLESCENT'S EXPERIENCE OF A SIBLING'S DEATH

The grief reaction experienced by adults usually includes the following features:

1. Sensations of somatic distress, such as tight throat, shortness of breath, need for sighing,empty abdomen feeling, lack of muscle power, generalised tension.
2. Intense pre-occupation with the image of the deceased person.
3. Strong feelings of guilt.
4. Loss of warmth towards others and tendency towards irritability and anger.
5. Disorientation.

In the child and adolescent these features are experienced in varying degrees, according to age, closeness of attachment to the child who died, and the ability of the family to deal with grief. Sometimes these immediate reactions to grief are blocked out because they are too painful. The full experience of grief may be delayed months or even years, only to be stirred up by some later loss or other stress, and then painfully re-lived. Siblings of the deceased child are often racked by feelings of guilt because of their rivalry with the chronically sick child for parental attention, their feelings of frustration with the child's illness and a wish that the child should die to get the process all over, and sometimes even statements made to the chronically ill child such as, "I wish you would die".

Siblings are commonly afflicted with anxiety and somatic complaints such as headache and abdominal pain which reflect both the stress of their loss and their fear for their own safety and health. It is important that parents re-assure the sibling that one does not die just by being sick, and also that when explaining death, the parents don't associate death with sleep or taking a trip or with a notion that God or someone took their brother or sister away.

In the two to four age group there is often a matter-of-fact curiosity about death. The implications of the death of an older sibling may not be comprehensible at that age until the reality of the sibling's absence has gradually dawned on the young child. The long illness which commonly preceeds the death of the child has usually already strained the sibling's relationships with parents and the dying child and sometimes sibling's can feel relieved that their brother or sister has finally died. However, in their deeper feelings the sibling may feel immensely guilty. The egocentricity

of the pre-schooler may lead the child to see death as a consequence of his or her own destructive words or wishes.

It is vitally important what happens and what the child is told at the time that a sibling dies. For instance, one adolescent, with whom I have worked, went into the intensive care unit to look at her sister after she had died. She opened her sister's eyes. The blank stare that she saw there remained an image that haunted her for months afterwards. In another case, the siblings of a teenage Chinese boy were terribly distressed by the fact that he had died with his eyes open, which in the family culture indicated that he, was not ready to die. The family context is a major influence on how children deal with a sibling's death.

Children's reactions to the death of their brother or sister are likely to be reflected in behavioural changes just as much as in clear verbal expression. Regression and aggression are common features of behavioural change. There may also be searching for the lost person in some of the familiar places where that person is usually met. However, despite the tendency for children to use denial, it is very likely that each bereaved child will at some point, with a sensitive care giver, express the grief reactions similar to those felt by adults. Katherine Paterson (1977) in her children's novel *Bridge to Terabithia* gives a moving and realistic account of a grief in a ten year old boy.

When children do use a lot of denial and carry on as though nothing has happened, their need to mourn may often be ignored. One boy comes to mind whose younger brother Paul died after a long illness and a very protracted death. He was unable to directly grieve but one month later was in a lot of trouble for scrawling on many walls the words "Paul is King" and the words "Paul is the best". In comforting the sibling of the child who has died it is important for parents and others to acknowledge the sadness that they won't see the brother or sister anymore.

Sibling grief reactions have been studied in detail in relation to Sudden Infant Death Syndrome. These grief reactions illustrate two main points. The first is that children form attachments even to the expected new child in the family before that child is born. Secondly, that children's grief reactions cannot be seen in isolation from their parent's reactions and that many of the problem behaviours reported in the children's grief reactions may well reflect the change in the family system functioning caused by the parent's grief. A study by Burns, House and Ackenbauer (1986) illustrates behaviour problems in children who are grieving about the loss of a sibling. Behaviour such as crying, deterioration of school performance, death phobias, withdrawal, nightmares, bedwetting and discipline problems are most common.

Discipline problems may be due to a deterioration of family management during the period of the child's illness and/or during the time of the parent's grieving. Grieving parents often relax their behavioural limits normally set with children and also are less able to provide the high level of operant conditioning by which children are normally socialized. This means that the way we teach children social, adaptive and self-help skills is by reinforcing successive approximations of what we want them to do. We do this through lots of praise, approval and general reinforcement in our facial expressions and our voice. When parents are feeling down and overburdened they are unable to maintain this normal level of responsiveness to their children, and the children often see blank or depressed expressions on their parents faces no matter what their behaviour is like.

Another way in which the dying child can make an impact on the sibling is through the frequent absence of the mother from the home while she is in hospital staying overnight with the sick child. Major contributions to mental health have been made by groups such as the Association for the Welfare of Children in Hospital who have promoted our understanding of the impact of hospitalization upon children: for instance the separation from parents, the strange new surroundings and people and completely new routines, traumatic medical procedures etc. Hospital practices have changed dramatically in the past three decades to enable the child in hospital to have a parent staying overnight and often actively involved in hospital care. This has had an immensely positive impact on the experience of the child in hospital, but it has often had a negative effect on siblings. During times when the mother spends most of her time at the hospital with the child, especially if the hospital is some distance away from the family home, siblings can undergo severe separation stress. Not only is their mother emotionally drained by her ordeal and hence rushed, burdened, sapped of energy and irritable when she is with them, she is also absent

much of the time and the children are left with neighbours or even distributed amongst relatives for prolonged periods. The siblings can feel that they have lost their mother's love and concern and this separation can make the child anxiously attached to the mother and hence the child too becomes more irritable, clinging and difficult to manage.

LATER ADJUSTMENT PROBLEMS IN SIBLINGS

Cain, Fast and Erickson (1964) report a great variety of pathological sibling reactions to the death of a child. The great limitation of their report is that it is based upon data collected from clinical files ranging from outpatient evaluation to years of intensive inpatient treatment, so it is entirely a clinical sample. It is helpful to clinicians in understanding what dynamics are likely to be involved in the child and the family who present with a pathological grief reaction but it is less useful in understanding what the majority of siblings in the population experience in reaction to the death of their brother or sister.

The study of Pettle Michael and Lansdown (1986) is much more useful in understanding normal child reactions to the death of a sibling because they studied children who were not presenting to clinical settings with problems. Their paper discussed the results of a preliminary descriptive study of 28 children (from 14 families) whose brother or sister had died of cancer between 18 and 30 months previously. The paper by Pettle Michael and Landsdown will be discussed further below.

The paper by Cain, Fast and Erickson (1964) does warrant further discussion, bearing in mind it applies to the clinical sample. The sibling deaths in the cases they studied ranged widely from chronic or sudden illness (leukemia, asphyxiation, heart conditions, severe infections) to car accidents, drowning, burns, accidental shooting, severe beating and murder. Furthermore, the surviving siblings actual involvement in or even responsibility for the death of their sibling ranged widely. In at least one third of those cases the sibling had in a sense been significantly responsible for the death. Guilt reactions were very prominent. The children felt that they should have died too or should have died instead of the dead sibling. In some cases a wish to die was motivated by a wish to join the dead sibling. Many mulled over and over the nasty things they had thought, felt, said or done to the dead sibling.

Another characteristic of surviving siblings found was that they had distorted concepts of illness and death. Children's confidence in the reassurance from parents that they would not die till they grew old was very shaken by the death of the child at such a young age. In cases where there had been an emergency respiration procedure and tracheostomy, the surviving child had ghastly fantasies centred not around illness but upon adult murderers killing the struggling child. The sibling may see the tubes and monitors of the intensive care unit as very persecuting of the sibling.

Where the child had died following an illness, the siblings sometimes developed fearful concrete disease notions, for instance that coughs, colds and high temperatures or bruises could lead to death. Death was seen as constantly imminent and they even developed cautionary tales about sleep, wearing galoshes and even perhaps "he died because he did not eat his vegetables". These children's attitudes to hospital became very fearful. Doctors would be treated with suspicion. Some would also be puzzled as to how and why their loving God had killed or at best "taken away" their loved sibling. Belief in God sometimes became frightening rather than reassuring and many children developed an intense fear of death becoming convinced that they would die either at precisely the same age or from the same cause or under the same circumstances as their dead sibling. Their confidence in their parents as protectors were shattered. Death could strike at any moment. This reaction could also have been reinforced by parental over-protectiveness of the remaining children and a fearful vigilance against possible dangers.

Cain, Fast and Erickson (1964) report several cases where the parents even changed the living child's name to that of the dead child, while in other cases newly born children were given the dead child's exact name or his or her name slightly changed. This behaviour clearly indicates an unresolved grief reaction. Children in a replacement role are constantly aware of their parent's basic wish that this child, instead of the dead sibling, was dead. In many cases there were

consistently unfavourable comparisons made between the surviving children and their dead sibling. The comparisons were often relentless, quite open, even in parents who were aware of how damaging this was.

Cain, Fast and Erickson (1964) clearly documented the impact of parental mourning on the children in the family. In some extreme cases the parent's grief was so great that he or she required brief hospitalization and became severely withdrawn, preoccupied and depressed. Reactions included severe anxiety states, insomnia, nightmares, incessant talk and preoccupation about the dead child and the details of death, auditory hallucinations of the dead child and rage filled agitation. Amidst these reactions some parents were completely incapable of providing any love for or even attention to the remaining siblings and could not cope with basic household organization.

In summary, the review of clinical data by Cain, Fast and Erickson (1964) indicated that the determinants of children's response to the death of a sibling included; the nature of the death, the age and characteristics of the child who died, the child's degree of actual involvement in his or her sibling's death, the child's pre-existing relationship to the dead sibling, the immediate impact of the death upon the parents, the parents handling of the initial reactions of the surviving child, the reactions of the community, the death impact upon the family structure, the availability to the child and the parent's of various substitute care givers, the parent's enduring reactions to the child's death, major concurrent stresses upon the child and family and the developmental level of the surviving child at the time of the death. The effects upon the child obviously are not static, but undergo constant developmental transformation and evolution. They stressed that in child deaths the physician's responsibility to address bereavement issues applies not only to the parents, but to the entire family, including siblings.

Pettle Michael and Lansdown (1986) studied the impact of the death of children from cancer on the adaptation of the sibling's sometime after the death. They studied 28 children (from 14 families) whose brother or sister had died of cancer between 18 and 30 months previously. Behaviour checklists (Rutter) were completed by parents and teachers and self concept scales were administered to the children. A lengthy semi-structured interview was carried out and measures of parental adjustment were gathered. The length of the deceased child's illness, that is from the date of diagnosis to the death, varied from seven days to 148 months.

On the self concept scale their results showed that children perceived themselves to be significantly different from both their ideal self and their dead sibling. The children's perceptions of the dead sibling were found to be significantly higher than even their ideal self. An inspection of the raw data showed that in comparing "self as I am" with either ideal self or the sibling, the children always rated themselves unfavourably. Of the behaviour checklists, the Rutter Scale A (parent report) were available for 21 children and the Scale B scores (teachers report) were available for 26 children. Ten children (43.5% of the sample) were identified as experiencing appreciable emotional or behavioural difficulties, or both. There was no significant difference found between the self esteem scores of children scoring above the Rutter cut-off point for disturbance and below the cut-off point. There was negative correlation ($p = .05$) between self esteem scores and duration of illness suggesting that the shorter the duration of the illness, the greater the impact on the surviving sibling's view of him or herself. In the family measures there was no relation found between the parental measures of emotional disturbance (malaise inventory) and the measure of family adjustment. There was no significant relation found between the measure of family adjustment and the Rutter Scale scores or the child self esteem score or the length of the patient's illness or the time that had elapsed since the patient's death. It appears likely that the family adjustment measure (unpublished) was not very sensitive.

In the family interviews parents were asked about the prevalence of the events postulated in earlier reports as being helpful in promoting adjustment. These events include:

1. Having knowledge of the diagnosis and likely fatal outcome.
2. Participating in the patient's care, for example visiting regularly.
3. Having the opportunity to say goodbye in the terminal phase.
4. Having the sibling die at home.
5. Seeing the dead body.

6. Attending the funeral or cremation by choice, or being included in the family gathering.
7. Being given some of the patient's possessions.
8. Previously experiencing the death of a close relative or pet.

Pettle Michael and Lansdown (1986) allocated one point for each experience and this score was positively correlated (significantly) with self esteem scores obtained for each child. Most of these experiences were related to lower scores on the Rutter Behaviour Problem Checklists, but two of these items, namely having seen the child dead and having witnessed the terminal phase of the illness through their sibling dying at home, were related to poorer adjustment. Thus, some of the experiences thought to have beneficial effects on children's adjustment may in fact leave the surviving child with difficult memories and emotions to deal with. It should be noted also that having received no clear knowledge that their sibling was likely to die was also associated with poor adjustment. The family's approach to the death and events surrounding the death may be more important than any of these above experiences per se, but this needs further investigation.

There was some indication from the interview data that were not subject to analysis that many of the children had, in the early stages of adjustment, manifested behaviour problems, sleep disturbance and emotional difficulties, but these had since disappeared. Nevertheless, it is very notable that even at this point of investigation, 18 to 30 months after the death of a sibling, a high percentage of children were showing sufficient difficulties to be labelled as warranting psychiatric help on a well researched behaviour scale. Further studies of a prospective kind would help to identify those children at greater risk of developing adjustment problems and may clarify which experiences associated with sibling bereavement are likely to facilitate adjustment.

A particular group of children whom I feel require special attention are those who donate bone marrow to a sibling. Rather than feeling heroic many bone marrow donors feel disturbed by the fact that part of their body is circulating in their sibling's body with the potential to either save the sibling's life or contribute to the sibling's death through graft-versus-host disease. Siblings who donate marrow should be monitored for psychological maladjustment and offered special help if the sick child dies.

I feel that a major area of adaptation which wants rigorous investigation is the use of denial by children, adults and families as groups. Denial is often an adaptive response in the face of catastrophe or severe emotional pain. But it has its costs as well. We need further research to clarify what degree and duration of denial is adaptive and what interventions are helpful when denial becomes maladaptive.

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